NSW Parliamentary Inquiry into the impact of ambulance ramping and access block on the operation of hospital emergency departments in New South Wales

Following AMA(NSW) President, Dr Michael Bonning's appearance at the hearing for the inquiry into the impact of ambulance ramping and access block on the operation of hospital emergency departments in New South Wales, please find AMA(NSW)'s responses to the Committee's supplementary questions and questions taken on notice.

Response to supplementary questions

1. ***Can you outline how Payroll Tax is going to impact the viability of GPs who provide the primary healthcare that is critical to freeing up space in our hospitals?***

Most medical practices typically employ support staff (including receptionists and nurses) and engage doctors as independent contractors using a 'service entity' model. Under this model, the practice collects consultation income on behalf of doctors and then distributes it to those doctors after deducting a service fee.

While it was traditionally understood that doctors contracted under this model did not subject the practice to a payroll tax obligation, Revenue NSW has confirmed that it will broaden its application of payroll tax laws to encompass medical practices operating 'service entities'.

This change in Revenue NSW's stance on payroll tax for general practice will mean that a general practice may have to pay 4.85% on the payments to each doctor managed by the general practice. As an example, for a general practice providing services to a doctor who generates an average $250,000 in income (after costs), the general practice could have $12,125 in additional costs per doctor per financial year.

Further, if the State Government via Revenue NSW applies this change in payroll tax treatment retrospectively, general practices will be hit with punitive financial penalties and interest charges on payroll tax amounts that they did not have to pay in the past. This cost hurts the general practice, not the doctors themselves. Many general practices are already operating on thin margins and, further, have had to navigate significant changes in demand and their operations as a result of COVID-19. Payroll tax will do doubt push practices to consider whether they can continue to remain open.

In circumstances where NSW is already facing a GP-shortage, particularly in rural and regional Australia, payroll tax will further exacerbate challenges to healthcare access if some practices are forced to close their doors.

Further, there will be no incentive for doctors to become practice owners in this landscape or for doctors to work in modern team-based models of care. This is contrary to Federal Government funding models (such as Practice Incentive Payments), which are designed to incentivise doctors to move away from solo medical practice to models where a number of medical practitioners practice from the same location. This funding has been important to ensure the financial viability of general

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practices, given the failure of MBS rebates to keep pace with the actual costs of providing medical services.

Some of our members have expressed the view that the requirement to pay payroll tax will effectively mean the reallocation of Federal Government payments to the State Government, with ultimately no benefit to (and to the detriment of) general practice.

2. ***Can you outline to the committee how the current funding model between state and federal Governments is simply not working when it comes to resourcing our hospitals properly?***

The current funding formula, as outlined in our submission, is squeezing public hospital finances as the cost of providing hospital services exceeds the funding provided for them.

The current funding formula works off an activity-based model known as 'Activity-Based Funding' (ABF) whereby public hospitals are funded according to the amount and types of patients they treated in the previous year, adjusted for cost increases. Smaller regional hospitals with relatively low patient volume are an exception and are partially block funded.

The National Efficient Price determines how much the Federal Government will contribute to the cost of each type of public hospital service provided each year under the ABF framework i.e. funding is effectively indexed at the rate of the National Efficient Price. The National Efficient Cost determines how much the Federal Government will contribute in block funding to small regional hospitals.

The design of the National Efficient Price (use of an average cost) puts downward pressure on public hospital service costs. This is because hospitals that are providing a service at above the national average price will have to foot the bill for the portion that exceeds the average, whereas hospitals providing the same service at below the national average price will receive reimbursement that exceeds what it cost them to provide the service. While this has allowed public hospitals to achieve substantial efficiency gains, there are limits to the extent of efficiency gains that can be made.

It has become increasingly difficult for hospitals to find further efficiency gains to help them manage budgetary pressures, particularly with increased demand pressures (the causes of which were outlined at page 2 of our submission) and increasing cost pressures in recent years with the impact of global forces such as the pandemic, natural disasters and the war in Ukraine causing inflation to soar to a 32-year high.

The impact of these pressures is clear from the data. The first National Efficient Price (2012-13) was $4,808.[1] By 2021-22 it reached $5,597.69.[2] This represents an indexation for an average hospital

[1] Independent Hospital Pricing Authority, *National Efficient Price Determination 2012-13* (2012) 3.
[2] Independent Hospital Pricing Authority, *National Efficient Price Determination 2021-22* (2021) 7.

admission of 1.27 per cent per year (averaged over the period 2012/13 - 2021/22).[3] This rate of indexation is less than nurses' salary growth averaged over the period 2012-13 to 2019-20 (3.1% per year) and much lower than health inflation (i.e. how much hospitals pay for goods and services), which was 3.5 per cent per year averaged over the period June 2013 to June 2020. [4]

The Commonwealth and State and Territory governments have saved a lot of money from insufficient indexation of their contribution to public hospitals through the use of the National Efficient Price and, further, by capping annual funding growth at 6.5 per cent on the previous year. However, this funding is failing to match the increasing cost of delivering healthcare when hospitals are experiencing record-high demand. Catchup of the backlog of services not delivered due to COVID-19 cancellations of elective procedure are another substantial pressure that continues to penalise the health system.

The release of the Federal Government budget on 25 October 2022, which confirms it's additional funding beyond the national cap will not be renewed after 31 December 2022, does not give any reassurance that hospital pressures will be eased. This additional funding, which was intended as an exceptional Covid-19 measure, remains necessary to boost hospital activity and capacity as the pandemic and its effects are unlikely to respect a 31 December 2022 deadline.

3. What reservations do you have regarding Urgent Care Centres?

AMA (NSW)'s recognises the need to improve access to primary care services. General practitioners are highly trained, having undertaken both hospital-based experience and the additional training of a general practice fellowship. They are accordingly well placed to provide care in urgent circumstances. However, AMA(NSW) completely opposes any model of stand-alone service such as 'Urgent Care Centres'. The idea of creating new physical locations in which health care is provided is not new. The GP SuperClinic model was an example of such a policy in which millions of dollars of health spending was allocated to duplicating the services provided effectively by privately run general practice. To the extent to which SuperClinics still operate, they run on the same basis as a usual general practice, at much higher start up cost.

Similarly, there has been a long history of co-located "general practice" style services located nearby or on hospital campuses. These models have also failed because they took away from the workforce of existing general practice, rather than enhancing it.

AMA(NSW) is concerned this model could harm the viability of general practice as the bulk-billed services offered by Urgent Care Centres (which receive state funding not available to general practice) may attract patients away from those general practices that operate on a mixed-billing

[3] Australian Institute of Health and Welfare, *Australian Hospital Resources – 2019-20*, Table 3.3; Australian Institute of Health and Welfare, *Australian Hospital Resources 2013- 14: Australian hospital statistics*, Table 5.4.

[4] Australian Bureau of Statistics, *Consumer Price Index, Australia* (Catalogue No 6401.0, 29 July 2020); AMA Research and Reform Unit, 'Public hospitals: Cycle of crisis' (Research Paper, Australian Medical Association, October 2021) 25.

system. We also have concerns about how Urgent Care Centres will be adequately staffed without drawing existing staff away from general practice, noting rural and remote areas of NSW are facing a workforce crisis. Supporting well established general practices to provide more services and to extend their hours is the only way to effectively provide urgent care without damaging the care provided by general practice and other community health providers. This model works with minimal added costs so that state funding can be directed to properly remunerating health care workers.

AMA(NSW) supports the development of an Urgent Care Services based model which should involve sustainable and additional services for urgent conditions in partnership with general practice and other community health providers.

An example of this preferred model is Western Sydney's Value Based Urgent Care (VBUC) which has seen the establishment of Urgent Care Services (UCS) that are run predominately via a network of general practices in partnership with other community health providers.[5] This model has a focus on upskilling and utilising existing primary care resources and this focus ensures a sustainable approach to urgent care that ensures the right services are provided at the right time and in the right place. These services are commissioned to provide comprehensive and accessible care with input from local community health providers, GPs, local emergency clinicians and community members. These services are not set up in competition with local health care providers.

4. ***What do you believe are the top three actions a NSW Government can undertake to reduce ambulance ramping and access block in Emergency Departments?***

As per the recommendations in our submission and reiterated in this response, AMA(NSW) believes action by the NSW Government to reduce ambulance ramping and access block should include:

1. Providing additional funding for extra beds and staff to address current capacity issues. As explained above, a barrier to securing such additional funding is the current funding formula between the State and Federal Governments which is constraining the ability of public hospitals to address increasing demand pressures. AMA(NSW) calls for the NSW Government's support in urging the Federal Government to increase its contribution to funding as recommended in our submission.

2. Funding out-of-hospital care alternatives to address avoidable admissions and readmissions. As discussed in this response, general practice plays a key role in facilitating out-of-hospital alternatives including Hospital in the Home, Urgent Care Services and Integrated Care and more needs to be done to ensure the viability of general practice particularly in regional, rural and remote areas.

3. Further to 2 above, AMA(NSW) calls for the NSW Government via Revenue NSW to exclude general practices from the application of payroll tax for reasons outlined in this response.

[5] 'Value Based Urgent Care', Western Sydney Care Collective (Web Page) <https://westernsydneycarecollective.com.au/value-based-urgent-care/>.

Response to questions on notice

1. ***What measures are you seeing that they're putting in place—that are effective—to deal with this backlog of elective surgery, if any? And how many years? Do you see a light at the end of the tunnel?***
   Is there a plan to have dealt with a significant portion of this hopefully, for example, by two years, by three years, by four years? Does the AMA have a clear idea of that? Have you been discussing with NSW Health what that looks like?
   (Question by Ms Cate Faehrmann, transcript page 5)

We have seen some NSW Health measures being put in place to address the backlog of elective surgery, particularly with the outsourcing of elective surgeries to the private sector.[6] However, AMA (NSW)'s preference has always been that Local Health Districts should be planning to maintain as much elective surgery as possible within the public hospital system and that private hospitals maintain their core business of caring for private patients to ensure the ongoing viability of the private health care system. Further, keeping as much work as possible in the public system ensures patients remain within appropriate models of care, that doctors-in-training continue to access training opportunities, and VMOs are operating with appropriate cover and resourcing available to them and their patients.

We note the NSW Government's two-year plan to invest a further $408 million into elective surgery expenditure as part of the 2022-23 Budget.[7] Although a positive step towards increasing elective surgery activity and fast-tracking these surgeries for public patients, AMA(NSW) again stresses that medical workforce shortages across the NSW public health system remain a significant barrier to achieving this. As noted in our submission, providing additional funding to address capacity issues should be prioritised (for example, investing in incentives to engage prospective staff from overseas) to better facilitate the resumption of elective surgeries.

2. ***In the funding models that exist in that space, what are you seeing to attract GPs into those positions in the primary care market? Are there initiatives underway at the moment that are seeing an increase or potentially could see an increase, particularly in rural and regional communities?***
   (Question by the Hon. Scott Farlow, transcript page 6)

We note the Federal Government has in place several initiatives to incentivise working in general practice – particularly in rural, regional and remote areas. The Practice Incentive Program offers incentives to general practices including, but not limited to:

- After-hours incentives – to support the provision of patient care in both social and unsociable after-hours periods;

[6] NSW Health, Submission No 35 to Portfolio Committee No. 2 – Health, Parliament of New South Wales, *Inquiry into the impact of ambulance ramping and access block on the operation of hospital emergency departments in New South Wales* (23 September 2022) 40.
[7] Ibid 41.

- Teaching payments – to encourage the provision of teaching sessions to medical students and;
- Rural loading initiatives – as a means of recognising the unique challenge of providing patient care in rural and remote areas.[8]

The More Doctors for Rural Australia Program (MDRAP) is a 3GA program that enables doctors who are non-vocationally registered to work in rural regions and access Medicare. MDRAP commenced in 2019 and is administered by NSW Rural Doctors Network. Under the Stronger Rural Health Strategy from the Commonwealth Government there are a number of programs beginning in medical school to encourage medical graduates to work in rural and regional areas and also to undertake training in those areas including general practice training.

Specific to incentivising rural medicine is the Workforce Incentive Program Doctor Scheme which provides financial incentives of up to $60,000 to eligible doctors practicing in regional, rural and remote communities who provide eligible primary care services.[9] This generally includes the provision of telehealth services, although eligibility is based on the doctor's physical practice or outreach location – not patient location.

However, as stated in this response, the effectiveness of these initiatives will be undermined by Revenue NSW's change in payroll tax treatment and we again emphasise the necessity for a payroll tax exemption for general practices.

On a State level, AMA(NSW) recommends the NSW Government work with the Federal Government and the Primary Health Networks to implement the GP Single Employer Model, which will provide GP registrars with comparable remuneration and entitlements to hospital-based colleagues, making general practice a more attractive option to doctors-in-training. As discussed in Dr Bonning's witness evidence, this model has been piloted in Murrumbidgee Local Health District[10] and provides participating doctors-in-training and a structured and supportive pathway towards specialisation in rural general practice. It is hoped this pathway will encourage greater retention of GPs in rural and remote areas after training is completed, which may be considered of greater importance given the tendency of trainees to flee back to metropolitan cities once they have obtained their specialist qualifications.

[8] 'Practice Incentives Program', Services Australia (Web Page) <https://www.servicesaustralia.gov.au/practice-incentives-program>.
[9] 'Workforce Incentive Program', Australian Government Department of Health and Aged Care (Web Page) <https://www.health.gov.au/initiatives-and-programs/workforce-incentive-program>.
[10] 'Murrumbidgee Rural Generalist Training Pathway', Murrumbidgee Local Health District (Web Page) <https://www.mlhd.health.nsw.gov.au/getmedia/0d396ca5-0028-4cca-99ac-e573dd90bda8/A4-Brochure-Rural-Generalist-Training-Pathway>.

3. ***Dr Bonning, with respect to the New South Wales position compared to other States, in particular, the diagram that you've included in your submission at figure 1 shows the number of approved/available public hospital beds per 1,000 population aged 65 and over for all States and Territories. Maybe on notice, will you provide those figures on a State-by-State basis to see how New South Wales compares?***
(Question by the Hon. Scott Farlow, transcript page 7)

We set out in the table below the number of available public hospital beds per 1,000 population aged 65 and over for all States and Territories. As can be seen in this table, the steepest decline in available beds per 1,000 population aged 65 and over for the period 2014-15 to 2020-21 was observed in South Australia (-23%), with New South Wales in second place (-16%).

Available beds per 1,000 population aged 65 and over[11]

	2014–15	2015–16	2016–17	2017–18	2018–19	2019–20	2020–21	Change since 2014-15	Change since 2019-20
New South Wales	17.73	17.37	16.94	16.60	16.14	15.25	14.90	-16%	-2%
Victoria	14.90	15.40	15.33	15.06	14.90	14.25	13.89	-7%	-3%
Queensland	17.15	16.82	16.47	15.93	15.75	15.48	15.06	-12%	-3%
Western Australia	17.00	16.17	16.27	15.78	15.58	14.57	14.44	-15%	-1%
South Australia	16.68	15.80	15.43	14.34	13.84	13.23	12.79	-23%	-3%
Tasmania	13.76	13.49	12.91	12.81	13.07	13.11	13.63	-1%	4%
Australian Capital Territory	22.42	22.29	21.42	19.98	19.80	19.65	19.64	-12%	0%
Northern Territory	40.86	39.15	37.56	48.83	50.31	47.45	49.63	21%	5%
Total public hospitals	16.79	16.59	16.30	15.91	15.64	14.97	14.67	-13%	-2%

All other States and Territories also saw a decline of varying levels over the same period, save for the Northern Territory, which saw an increase in available beds by 21%. Based on the available data, this appears to be attributed to an usually large increase in average available beds in the Northern Territory by 61.4% for the period 2014-15 to 2020-21, despite also reporting the largest increase in its population aged 65 and over (32.9% over the same period). In comparison, New South Wales experienced a decrease in available beds by 1.1% and an increase in its populated aged 65 and over

[11] Australian Institute of Health and Welfare, *Hospital Resources 2020–21: Australian hospital statistics*, Table 4.6; Australian Institute of Health and Welfare, *Hospital Resources 2019-20: Australian hospital statistics*, Table 4.6; Australian Bureau of Statistics, 'Quarterly Population Estimates (ERP), by State/Territory, Sex and Age', *Stat Data Explorer beta* (Web Page) <https://explore.data.abs.gov.au/vis?tm=quarterly%20population&pg=0&df[ds]=ABS_ABS_TOPICS&df[id]=ERP_Q&df[ag]=ABS&df[vs]=1.0.0&hc[Frequency]=Quarterly&pd=2015-Q2%2C2021-Q2&dq=..8599%2BA80%2BA75%2BA70%2BA65..Q&ly[cl]=TIME_PERIOD&ly[rw]=REGION>.

by 17.7% over the same period. This data is presented in the below tables for all States and Territories.

	2014–15	2015–16	2016–17	2017–18	2018–19	2019–20	2020–21	Change since 2014-15	Change since 2019-20
Average available beds[12]									
New South Wales	21,018	21,152	21,147	21,253	21,224	20,722	20,787	-1.1%	0.3%
Victoria	13,909	14,315	14,667	14,820	15,084	14,949	14,913	7.2%	-0.2%
Queensland	11,771	12,005	12,213	12,271	12,597	12,889	13,032	10.7%	1.1%
Western Australia	5,689	5,607	5,876	5,947	6,130	6,034	6,243	9.7%	3.5%
South Australia	4,923	4,794	4,816	4,608	4,581	4,532	4,514	-8.3%	-0.4%
Tasmania	1,299	1,314	1,304	1,340	1,416	1,472	1,583	21.9%	7.5%
Australian Capital Territory	1,068	1,106	1,110	1,078	1,110	1,151	1,189	11.3%	3.3%
Northern Territory	664	664	664	907	977	977	1,072	61.4%	9.7%
Total public hospitals	**60,340**	**60,957**	**61,797**	**62,224**	**63,119**	**62,726**	**63,333**	5.0%	1.0%
Population aged 65 and over[13]									
New South Wales	1185361	1217382	1248531	1280604	1314756	1359210	1395247	17.7%	2.7%
Victoria	933679	929563	956692	984253	1012197	1049230	1073904	15.0%	2.4%
Queensland	686209	713927	741625	770074	799766	832565	865361	26.1%	3.9%
Western Australia	334714	346757	361165	376888	393379	414208	432382	29.2%	4.4%
South Australia	295118	303475	312205	321342	331023	342533	353007	19.6%	3.1%
Tasmania	94404	97392	101040	104619	108338	112290	116133	23.0%	3.4%
Australian Capital Territory	47630	49622	51824	53964	56060	58567	60525	27.1%	3.3%
Northern Territory	16252	16959	17677	18573	19421	20592	21601	32.9%	4.9%
Australia	**3,593,367**	**3,675,077**	**3,790,759**	**3,910,317**	**4,034,940**	**4189195**	**4318160**	20.2%	3.1%

[12] Australian Institute of Health and Welfare, *Hospital Resources 2020–21: Australian hospital statistics*, Table 4.6; Australian Institute of Health and Welfare, *Hospital Resources 2019-20: Australian hospital statistics*, Table 4.6.

[13] Australian Bureau of Statistics, 'Quarterly Population Estimates (ERP), by State/Territory, Sex and Age', *Stat Data Explorer beta* (Web Page) <https://explore.data.abs.gov.au/vis?tm=quarterly%20population&pg=0&df[ds]=ABS_ABS_TOPICS&df[id]=ERP_Q&df[ag]=ABS&df[vs]=1.0.0&hc[Frequency]=Quarterly&pd=2015-Q2%2C2021-Q2&dq=..8599%2BA80%2BA75%2BA70%2BA65..Q&ly[cl]=TIME_PERIOD&ly[rw]=REGION>.